

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07138

7171

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R. F. D. #1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alphild Jenny Anderson</u>			4. DATE OF DEATH <u>July 28</u> 19 <u>56</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/3/1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Carlson John</u>			14. MOTHER'S MAIDEN NAME <u>Jennie</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>Eastern Shore State Hospital</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis with cardiac vascular disease</u> DUE TO (c) <u>Cerebral arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>several</u> <u>years</u> <u>several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/7</u> , 19 <u>56</u> , to <u>7/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/28</u> , 19 <u>56</u> , and that death occurred at <u>12:13 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. Virkutis</u>		ADDRESS (Street, city or town, state) <u>Eastern Shore State Hospital</u> DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>Dr. Virkutis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-29-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kevin R. Wilson</u> ADDRESS <u>Princess Anne, Md.</u>				24a. REC'D BY REGISTRAR <u>John H. H. S.</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
DECEASED		MALE		35		JAN 1 1920		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
DECEASED		FEMALE		25		JUL 15 1930		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		MALE		45		MAY 10 1910		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		FEMALE		30		SEP 5 1925		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		MALE		55		FEB 20 1900		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		FEMALE		40		OCT 12 1915		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		MALE		60		APR 8 1895		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		FEMALE		50		NOV 3 1905		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		MALE		70		JUN 18 1885		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		FEMALE		65		MAR 22 1890		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		MALE		80		DEC 1 1875		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		FEMALE		75		AUG 10 1880		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		MALE		90		MAY 15 1865		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		FEMALE		85		FEB 28 1870		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		MALE		95		JAN 1 1855		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	
DECEASED		FEMALE		100		DEC 1 1845		MASSACHUSETTS		MASSACHUSETTS		MASSACHUSETTS		UNITED STATES	

RECEIVED
AUG 7 1956
BUREAU V. R.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07139

7172

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 18 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SIDNEY Middle ARCHBELL Last ARCHBELL		4. DATE OF DEATH Month JULY Day 4 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-99
9. AGE (In years last day) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min. 56	IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NORTH CAROLINA	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH ARCHBELL		14. MOTHER'S MAIDEN NAME MARY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. EASTERN SHORE STATE HOSPITAL RECORDS	
17. INFORMANT Address EASTERN SHORE STATE HOSPITAL RECORDS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEMORRHAGIC PANCREATITIS 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-7 , 19 53 , to 7-4 , 19 56 , that I last saw the deceased alive on 7-3 , 19 56 , and that death occurred at 2:50 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE George E. Currier M.D.		ADDRESS (Street, city or town, state) Cambridge, Md. DATE SIGNED 7/4/56	
PHYSICIAN'S NAME (Type) GEORGE E. LURRIER			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/6/56	
22c. NAME OF CEMETERY OR CREMATORY CHESTER		22d. LOCATION (City, town, or county) (State) CHESTER TOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Wells ADDRESS Chester town Md		24a. REC'D BY REGISTRAR DATE July 6, 1956 24b. REGISTRAR'S SIGNATURE John W. Wells	

CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 18

Name of Deceased		DORCHESTER	
Age		18 M.	
Sex		FEMALE	
Race		WHITE	
Date of Birth		9-13-17	
Place of Birth		NORTH CAROLINA	
Date of Death		MAY	
Place of Death		EASTERN SHORE STATE HOSPITAL	
Cause of Death		ACUTE PERICARDIAL INFARCTION	
Duration of Illness		3 DAYS	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		JUL 6 1958	
Bureau No.		[Number]	

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JUL 6 1958
BUREAU V. 8

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 2yrs. 6mos. 3das. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle - Last Bundick		4. DATE OF DEATH Month July Day 17 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-5-70
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 5 Days 17	IF UNDER 24 HRS. Hours 17 Min. 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Elijah Miles	
14. MOTHER'S MAIDEN NAME Sallie Matthews		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. --		17. INFORMANT Address RECORDS: Eastern Shore State Hospital Cambridge, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 420.1 (c) 5 Min.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-19-56	
22c. NAME OF CEMETERY OR CREMATORY M.E. Cemetery		22d. LOCATION (City, town, or county) (State) Greenbackville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson ADDRESS Pocomoke		24a. REC'D BY REGISTRAR July 19 1956	
24b. REGISTRAR'S SIGNATURE John Mace Jr.		DATE SIGNED 7/17/56	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. F.

JUL 19 1956

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7174
CERTIFICATE OF DEATH

Reg. Dist. No.

07141

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 mo. 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill	
3. NAME OF DECEASED (Type or print) First Thomas Middle Wesley Last Burke		4. DATE OF DEATH Month July Day 2 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1871
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Burke		14. MOTHER'S MAIDEN NAME Louise Mattidge	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT RECORDS: Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Senility			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Senile Brain Disease, with psychosis 19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 1 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 21 , 19 56 , to July 2 , 19 56 , that I last saw the deceased alive on July 2 , 19 56 , and that death occurred at 3:00 M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. Simon Virkutis		M.D. Eastern Shore State Hosp., Cambridge, Maryland	
PHYSICIAN'S NAME (Type) Dr. Simon Virkutis		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF July 5 1956		22c. NAME OF CEMETERY OR CREMATORY Shore Hill	
22d. LOCATION (City, town, or county) (State) Snow Hill, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE John Mace Jr.	
ADDRESS Shore Hill		24a. REC'D BY REGISTRAR DATE JUL 5 1956	
24b. REGISTRAR'S SIGNATURE John Mace Jr.			

RECEIVED

7175

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 6 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #1		d. STREET ADDRESS 1308 N. Ensor Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Henrietta A. Campbell		4. DATE OF DEATH Month Day Year 7 20 1956	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-09
9. AGE (In years lost birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 5 8	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Work		10b. KIND OF BUSINESS OR INDUSTRY Cosmetics	11. BIRTHPLACE (State or foreign country) Golden Hill, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Woolford	
14. MOTHER'S MAIDEN NAME Catherine Dorsey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-07-4096		17. INFORMANT Florine M. Allen Address 1308 N. Ensor Street Baltimore 2, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 19, 1956 , to July 20, 1956 , that I last saw the deceased alive on July 20, 1956 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 227 Pine St-Cambridge, Md.-7-20-56			
ACTUAL SIGNATURE J. Edwin Fassett M.D. J. Edwin Fassett, M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-24-56	22c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore City, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Bullen		ADDRESS Havre de Grace, Md.	24a. REC'D BY REGISTRAR JUL 25 1956
		24b. REGISTRAR'S SIGNATURE John Mace, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar			
John Doe		Male		45		Jan 1, 1910		Maryland		123 Main Street		Heart Disease		Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.			
Occupation		Married		Single		Widowed		Divorced		Last Seen Alive		Date of Last Seen Alive		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar			
Teacher		Yes		No		No		No		Jan 10, 1955		Jan 15, 1955		Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.			
Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Heart Disease		Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955		10:00 AM	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death	
Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955		10:00 AM		Baltimore	
Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death	
J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death	
Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955		10:00 AM		Baltimore		J. Doe, M.D.		J. Doe, M.D.		Jan 15, 1955		10:00 AM		Baltimore	

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CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna, Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna, Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS R.F.D.			
3. NAME OF DECEASED (Type or print) Fred. Douglas Camper				4. DATE OF DEATH Month July Day 21 Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 10, 1875		9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm employee		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Camper				14. MOTHER'S MAIDEN NAME Annie Chase,			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Fannie R. Young, Vienna, Md. R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 July , 19 56 , to 21 July , 19 56 , that I last saw the deceased alive on 21 July , 19 56 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED 7-21-56 ACTUAL SIGNATURE J. Edwin Fassett M.D. PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 23, 1956		Cross Roads Cemetery		Vienna, R.F.D. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton & Son. Federalsburg, Md.				24a. REC'D BY REGISTRAR DATE July 23, 1956		24b. REGISTRAR'S SIGNATURE John Kae, R.D.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle VIRGINIA Last CARE		4. DATE OF DEATH Month JULY Day 27 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-1882
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSE		9b. AGE (In years last birthday) 74 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME EDWARD V. BIERY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME MATILDA V. WARNER	
16. SOCIAL SECURITY NO.		17. INFORMANT Address EASTERN SHORE STATE HOSPITAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO BRONCHITIS PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZED ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-7-1953 to 7-27-1956 , that I last saw the deceased alive on 7-27-1953 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Simon Virkutis M.D.		ADDRESS (Street, city or town, state) EASTERN SHORE STATE HOSPITAL DATE SIGNED	
PHYSICIAN'S NAME (Type) SIMON VIRKUTIS MD.		CAMBRIDGE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 30, 1956	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill		22d. LOCATION (City, town, or county) (State) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newman + Son ADDRESS		24a. REC'D BY REGISTRAR John H. D. DATE July 30, 1956	
		24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07145

7178

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 3mo. 27 das.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Walton Last Cheezum		4. DATE OF DEATH Month July Day 1 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-23-78
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Unkn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Cheezum		14. MOTHER'S MAIDEN NAME Cely Blades	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis With Cardiovascular Disease 422.1 DUE TO Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - (c) -			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated With Senile Brain Dis., W. Psy. Reac.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5 , 19 56 , to July 1 , 19 56 , that I last saw the deceased alive on July 1 , 19 56 , and that death occurred at 9:10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Simon Virkutis		ADDRESS (Street, city or town, state) Eastern Shore St. Hospital, Cambridge, Md.	
PHYSICIAN'S NAME (Type) Dr. Simon Virkutis		DATE SIGNED July 3, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JULY 4, 1956	
22c. NAME OF CEMETERY OR CREMATORY SPRING HILL CEMETERY		22d. LOCATION (City, town, or county) (State) EASTON, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Carroll		24a. REC'D BY REGISTRAR John Ray, R.D.	
ADDRESS EASTON, MD.		DATE July 3, 1956	

7163

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
13 TOWN <u>Cambridge</u>				STREET ADDRESS (If rural give location) <u>77 Washington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md Hospital</u>							
3. NAME OF DECEASED: (First) <u>George</u>		(Middle)		(Last) <u>Dennis</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>7</u> <u>28</u> <u>19 56</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 20, 1894</u>		9. AGE last birthday: <u>62</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wesley Dennis</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>229-10-5945</u>		17. INFORMANT & ADDRESS: <u>Cygnus Ross, Daughter</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
156.1 IMMEDIATE CAUSE (A) <u>Carcinoma of Liver</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 7, 19 56</u> , to <u>July 28, 19 56</u> , that I last saw the deceased alive on <u>July 28, 19 56</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Edwin Fasset</u>		J. Edwin Fasset, M.D.		ADDRESS <u>227 Pine St-Camb., Md.</u>		DATE SIGNED <u>7-30-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>8-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Silent City Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge-Do-Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 29, 1956</u>		REGISTRAR'S SIGNATURE <u>J. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Leon Henry</u>		ADDRESS <u>Cambridge, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7164

CERTIFICATE OF DEATH

07147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Athol	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Gen. Hospt.		d. STREET ADDRESS Route, Mardela, Maryland.	
3. NAME OF DECEASED (Type or print) First Edward Middle M. M. Last Donoho		4. DATE OF DEATH Month July Day 6. Year 56.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1876.
9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months 11 Days 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming.	
11. BIRTHPLACE (State or foreign country) Maryland (Athol)		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Donoho		14. MOTHER'S MAIDEN NAME Emily Hustin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Anna Donoho (Wife)		Address R.D. Mardela, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular Fibrillation DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Brachial artery, right, embolism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 15, 1956 to July 6, 1956 , that I last saw the deceased alive on July 5, 1956 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Lewis M. Burdette		ADDRESS (Street, city or town, state) City Office Bldg.	
PHYSICIAN'S NAME (Type) Lewis M. Burdette		DATE SIGNED 7/6/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 8. 56.	
22c. NAME OF CEMETERY OR CREMATORY Emanuel Church Cemetery		22d. LOCATION (City, town, or county) (State) Mardela, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co.		ADDRESS Salisbury, Maryland.	
24a. REC'D BY REGISTRAR JUL 9 1956		24b. REGISTRAR'S SIGNATURE John Mace, Jr.	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

07148

Reg. Dist. No. 116

7179

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>2yrs, 8mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		<u>22X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural give location) <u>Route # 4</u>			
3. NAME OF DECEASED (Type or Print) <u>Dorothy Winifred Dykes</u>				4. DATE OF DEATH (Month) <u>July</u> (Day) <u>20</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>December 2, 1894</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jobe W. Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Lavina Massey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Hospital Records, Eastern Shore State Hosp.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
491X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>						Several Yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Paranoid State</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 10, 1953</u> to <u>July 20, 1956</u> , that I last saw the deceased alive on <u>July 20, 1956</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above. SIGNATURE <u>S. Vinkul</u> ADDRESS (Street, city, town, state) _____ DATE SIGNED _____ M.D. <u>Eastern Shore State Hosp, Cambridge Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 23, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Dykes Family Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>	
24. REC'D BY REGISTRAR <u>JUL 23 1956</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Shelton</u>		ADDRESS <u>Salisbury Md.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07149

CERTIFICATE OF DEATH

Reg. Dist. No. 114

7180

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>About 15 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>MEDEORD</u> Last <u>HASTINGS</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>19 56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/3/73</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Medford</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Sard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Eastern Shore State Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchopneumonia</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paranoid Condition</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>9</u> p. m. 19 <u>56</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/15</u> , 19 <u>52</u> , to <u>7/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>7/24</u> , 19 <u>56</u> , and that death occurred at <u>4:40 a. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. <u>E.S.S. Hospital, Cambridge, Md.</u> <u>7/24/56</u>			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 26, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Saint Paul Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Williamsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Trampton, Son Federal Springs Md.</u>		24a. REC'D BY REGISTRAR DATE <u>July 26/56</u>	
24b. REGISTRAR'S SIGNATURE <u>John H. B. D.</u>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise.

BUREAU V. S.

JUL 31 1956

RECEIVED

7165

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Dorchester.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge Hospital.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna, Rural.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Hospital				d. STREET ADDRESS R.F.D.			
3. NAME OF DECEASED (Type or print) First Almeda Middle Ellis Last Hoerneck.				4. DATE OF DEATH Month July Day 20 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4"1870	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sydney T. Ellis.				14. MOTHER'S MAIDEN NAME Nannie J. Phillips.			
15. WAS DECEASED DEVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Sydney T. Ellis. Irvington, N. J.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism 570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis & arteriosclerosis DUE TO (c) Small gut obstruction sec to adhesions						INTERVAL BETWEEN ONSET AND DEATH 1 minute 2 hrs 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post-operative / day						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from July 20, 1956 , to July 20, 1956 , that I last saw the deceased alive on July 20, 1956 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE J. U. Thompson				ADDRESS (Street, city or town, state) Cambridge, Md			
PHYSICIAN'S NAME (Type) J. U. Thompson				DATE SIGNED July 21, 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 23, 1956		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suffolk, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton & Son. Federalsburg, Md.				24a. REC'D BY REGISTRAR DATE July 23, 1956		24b. REGISTRAR'S SIGNATURE John H. H. D.	

13
67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2. The first observation was the absence of any significant correlation between the two variables.

BUREAU V. 5

JUL 31 1956

RECEIVED

7166

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>33 Park Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Tinia</u> Middle <u>C.</u> Last <u>Kane</u>				4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1865</u>		9. AGE (In years last birthday) yrs. <u>90</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dor-Co-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Cephas</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Cephas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-26-0885</u>		17. INFORMANT Address <u>James Kane-Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Decompensation</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>April 1, 1956</u> , to <u>July 3, 1956</u> , that I last saw the deceased alive on <u>July 3, 1956</u> , and that death occurred at <u>2 A. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>227 Pine St-Cambridge, Md.</u> <u>-7-6--56</u>							
ACTUAL SIGNATURE <u>J. Edwin Fassett</u>		M.D. <u>227 Pine St-Cambridge, Md.</u>					
PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7-7-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge-Dor-Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Lawrence Jr.</u>				ADDRESS <u>High St-Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>July 7, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>John H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

10 15 20

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07152

7167 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>25 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>517 Oakley Street</u>			
3. NAME OF DECEASED (Type or Print) <u>Emmons</u> <u>Smith</u> <u>Murphy</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 23, 1956</u> 19 <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 25, 1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Restaurant Operatort</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Bishops Head, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Zebulon R. Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Malissa Todd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>220-32-1062 A</u>		17. INFORMANT & ADDRESS <u>517 Oakley St.</u> <u>Mrs. Elizabeth G. Murphy Cambridge, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>443x</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				<u>Hypertensive CVD</u>		<u>6 Days</u>	
ANTECEDENT CAUSE(S) DUE TO (B)						<u>yes</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-17</u>, 19<u>56</u>, to <u>7-23</u>, 19<u>56</u>, that I last saw the deceased alive on <u>7-23</u>, 19<u>56</u>, and that death occurred at <u>4:00 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. B. Bannan</u> M.D.				ADDRESS (Street, city, town, state) <u>Cambridge</u>		DATE SIGNED <u>7-23-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 25, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John H. H.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Reuneth K. Howard</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE <u>July 25, 1956</u>							

CERTIFICATE OF DEATH

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Cardinal Kennedy
Hypertension CVD

C. J. J.
Jr.

BUREAU A. J.

JUL 31 1956

RECEIVED

Cardinal Kennedy

Cardinal Kennedy

INSTRUCTIONS

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07153

7181

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN since 2/10/54	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	
d. NAME OF HOSPITAL (If not in hospital, give street address) Eastern Shore State Hospital		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Sarah Richardson		4. DATE OF DEATH Month July Day 7 Year 19 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1879
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		9b. KIND OF BUSINESS OR INDUSTRY Unknown	9c. AGE (In years lost birthday) 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. BIRTHPLACE (State or foreign country) Maryland		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. FATHER'S NAME Charles Davis		12. MOTHER'S MAIDEN NAME Sarah	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		14. SOCIAL SECURITY NO. Unknown	
15. INFORMANT Eastern Shore State Hospital Records		Address	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with Cerebral Arteriosclerosis			
17. INTERVAL BETWEEN ONSET AND DEATH 2 days		18. several years	
19. several years		20. several years	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		24. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that I attended the deceased from 2/10 , 19 54 , to 7/7 , 19 56 , that I last saw the deceased alive on 7/7 , 19 56 , and that death occurred at 6:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert H. Reddick, M.D.		ADDRESS (Street, city or town, state) State Hospital, Cambridge, Md. DATE SIGNED 7/7/56	
PHYSICIAN'S NAME (Type) Robert H. Reddick, M.D.		State Hospital, Cambridge, Md.	
28. BURIAL, CREMATION, REMOVAL (Specify) Removal		29. DATE THEREOF July 7 '56	
30. NAME OF CEMETERY OR CREMATORY Bon View		31. LOCATION (City, town, or county) (State) Baltimore, Md.	
32. FUNERAL DIRECTOR'S SIGNATURE Maryland Anatomical Board		ADDRESS	
33. REC'D BY REGISTRAR July 12 '56		34. REGISTRAR'S SIGNATURE John Lee, M.D.	

CERTIFICATE OF DEATH

Date of Death		Place of Death		Cause of Death	
July 18, 1956		Baltimore, Md.		Chronic Bronchitis	
Age		Sex		Race	
75		Male		White	
Marital Status		Occupation		Education	
Married		Retired		High School	
Usual Residence		Place of Birth		Date of Birth	
Baltimore, Md.		Baltimore, Md.		July 18, 1881	
Physician		Manner of Death		Signature of Physician	
Dr. J. H. Smith		Natural		[Signature]	
Coroner		Burial Place		Date of Burial	
[Signature]		Baltimore, Md.		July 20, 1956	
Registrar		County		City	
[Signature]		Baltimore		Baltimore	
Date of Report		Signature of Registrar		Official Seal	
July 19, 1956		[Signature]		[Seal]	

RECEIVED
JUL 18 1956
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7182

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman Island	
c. LENGTH OF STAY IN 1b 1 yr.		d. STREET ADDRESS 20x.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELMER Middle NADELL Last SINCLAIR		4. DATE OF DEATH Month July Day 3 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/81
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) merchant		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Bradford B. Sinclair		14. MOTHER'S MAIDEN NAME Mary Frances Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Eastern Shore State Hospital records	
17. INFORMANT Eastern Shore State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x Corebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <input type="checkbox"/> p. m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 30 , 19 55 , to July 3 , 19 56 that I last saw the deceased alive on July 3 , 19 56 , and that death occurred at 1:50p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas J. Dredge M.D. E.S.S.H., Cambridge		DATE SIGNED 7/3/56	
PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 7/5/56	22c. NAME OF CEMETERY OR CREMATORY Tilghman	22d. LOCATION (City, town, or county) (State) Talbot Md
23. FUNERAL DIRECTOR'S SIGNATURE Charles Moore Tilghman Inc ADDRESS		24a. REC'D BY REGISTRAR DATE July 5, 1956 24b. REGISTRAR'S SIGNATURE John H. H. H.	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		Baltimore, Md.		Baltimore, Md.		Heart Disease		Jan 15, 1955		10:00 AM		Home		J. Smith, M.D.		A. Jones, Registrar	
Occupation		Marital Status		Color		Height		Weight		Education		Previous Illnesses		Last Medical Examination		Last Medical Advice		Last Medical Treatment		Last Medical Examination		Last Medical Advice	
Teacher		Married		White		5' 10"		170 lbs		High School		None		Jan 10, 1955		None		None		None		None	
Signature of Deceased		Signature of Next of Kin		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Jury		Signature of Jury		Signature of Jury		Signature of Jury		Signature of Jury		Signature of Jury		Signature of Jury	
None		None		None		None		None		None		None		None		None		None		None		None	

RECEIVED
JUL 9 1955
BUREAU A. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7168

CERTIFICATE OF DEATH

Reg. Dist. No. 176

07155

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN 1b 25 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 38 Glasgow St.				d. STREET ADDRESS 38 Glasgow Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Addie Middle Poole Last Skinner				4. DATE OF DEATH July 25, 1956 Month July Day 25 Year 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1878		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months 7 Days 17	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Preston, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Poole				14. MOTHER'S MAIDEN NAME Emma Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT Nellie P. Skinner, 38 Glasgow St., Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemiplegia Rt. DUE TO (c) arteriosclerosis, Generalized						INTERVAL BETWEEN ONSET AND DEATH 7-8 days 1 Mo. 1 year +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-22 , 19 56 , to 7-25 , 19 56 , that I last saw the deceased alive on 7-23 , 19 56 , and that death occurred at 3:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust st. Cambridge, Maryland DATE SIGNED July 27, 1956							
ACTUAL SIGNATURE Eldridge H. Wolff		M.D. 15 Locust st. Cambridge, Maryland					
PHYSICIAN'S NAME (Type) Eldridge H. Wolff							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Old Trinity Cemetery		22d. LOCATION (City, town, or county) (State) Church Creek, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR July 27, 1956	
				24b. REGISTRAR'S SIGNATURE John H. H. H.			

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AUG 7 1956

BUREAU V. S.

7183
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddville		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At home of Edith & Wilton Todd				d. STREET ADDRESS Toddville		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANGIE NORA Middle JONES Last TODD				4. DATE OF DEATH Month July Day 2 Year 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1867		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Toddville, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Caleb Jones				14. MOTHER'S MAIDEN NAME Emily Todd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Miss Edith Todd Toddville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH Instant
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John Mace				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. John Mace M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		July 5, 1956	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 5, 1956	22c. NAME OF CEMETERY OR CREMATORY Family Burial Lot		22d. LOCATION (City, town, or county) (State) Toddville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge, Maryland		24a. REC'D BY REGISTRAR DATE July 5, 1956	
				24b. REGISTRAR'S SIGNATURE John Mace, M.D.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JUL 10 1956

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1807158

7169 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> <u>13</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67</u> <u>Cambridge Md Hospital</u>				STREET ADDRESS (If rural give location) <u>139 Pine St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Fred</u> <u>Purnell</u> <u>Waters</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>7</u> <u>26</u> <u>19 56</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>7-6-1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>factory</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Dor- Co-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Wilbur Waters</u>				14. MOTHER'S MAIDEN NAME: <u>Grace Camper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>217-10-8198</u>		17. INFORMANT & ADDRESS: <u>Cambridge, Md.</u> <u>Gertrude Waters-139 Pine St</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary heart disease</u> ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>56</u> to <u>July 26</u> , 19 <u>56</u> that I last saw the deceased alive on <u>July 26</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. SIGNATURE <u>J. Edwin Fassett, M.D.</u> ADDRESS <u>227 Pine St-Camb., Md.</u> DATE SIGNED <u>-7-28-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-29-56</u>		NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>July 29, 1956</u>		REGISTRAR'S SIGNATURE <u>John H. H.</u>		24. FUNERAL DIRECTOR <u>H.M. StClair, Jr.</u>		ADDRESS <u>High St-Camb., Md.</u>	

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AUG 7 1956

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07159

7170

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hurlock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) Linda L. Young		4. DATE (Month) (Day) (Year) OF DEATH: 7 26 1956	
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: 11-25-1886
9. AGE last birthday: 69 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
		11. BIRTHPLACE (State or foreign country): Dorchester Co-Md.	
13. FATHER'S NAME: Henry Kane		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME: Sarah Bank			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. 214 07 9090	
17. INFORMANT & ADDRESS: Isaac Young-East New Market, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>			
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) <u>Hypertensive Arteriosclerotic heart disease</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 1955 to July 28 1956 that I last saw the deceased alive on July 28, 1956, and that death occurred at M, from the causes and on the date stated above.			
SIGNATURE <u>J. Edwin Fassett</u>		DATE SIGNED <u>27-28-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-29-56	
NAME OF CEMETERY OR CREMATORY Family Cemetery		LOCATION (City, town, or county) (State) East New Market, Md.	
DATE REC'D BY LOCAL REGISTRAR July 29, 1956		REGISTRAR'S SIGNATURE <u>H. M. StClair, Jr.</u>	
24. FUNERAL DIRECTOR		ADDRESS H.M. StClair, Jr., High St-Camb., Md.	

CENTRAL TELEPHONE

HARVARD STATE TREATMENT OF BEARDS BUILDING

BUREAU V. S.

AUG 7 1956

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